Practitioner Session

Future of Palliative Medicine

Sushma Bhatnagar, Mayank Gupta¹

Department of Anesthesiology, Pain and Palliative Care, Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, ¹Department of Medical Intensive Care Unit and Pain, Rajiv Gandhi Cancer Institute and Research Centre, New Delhi, India

Address for correspondence: Dr. Sushma Bhatnagar, E-mail: sushmabhatnagar1@gmail.com

ABSTRACT

A 'need-supply' and 'requirement-distribution mismatch' along with a continuingneed explosion are the biggest hurdles faced by palliative medicine today. It is the need of the hour to provide an unbiased, equitable and evidence-based palliative care to those in need irrespective of the diagnosis, prognosis, social and economic status or geographical location. Palliative care as a fundamental human right, ensuring provision throughout the illness spectrum, global as well as region-specific capacity building, uniform availability of essential drugs at an affordable price, a multidisciplinary team approachand caregiver-support are some of the achievable goals for the future. This supplanted with a strong political commitment, professional dedication and 'public-private partnerships' are necessaryto tackle the existing hurdles and the exponentially increasing future need. For effectively going ahead it is of utmost importance to integrate palliative medicine into medical education, healthcare system and societal framework.

Key words: Capacity building, Corporate model, Curo-palliative approach, Future, Palliative medicine

INTRODUCTION

Palliative medicine has surely grown beyond leaps and bounds as far as the acknowledgement, needs, and concepts are concerned. Palliative care and end-of-life discussions have undergone a remarkable growth since the new millennium.^[1] The new millennium till now has witnessed a 138% increase in palliative care teams within hospital settings.^[2] It has come a long way from being a novice both as a concept and the providers providing it to a blossomed up healthcare system where the amateurs have become an authority training more apprentices to become palliative care wizards. However, inequitable distribution still prevails with majority of resources concentrated in the west. There is still inadequate access to palliative care by people suffering from non-cancer

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chronic ailments. Worldwide 20.4 million people, out of whom 6% are children and 78% are concentrated in low-middle income countries, require palliative care. [3] Only less than 10% of the present need is currently being met because of the barriers well known. [3] These statistics clearly depict a 'need-supply' and 'requirementdistribution' mismatch. With the explosion of population requiring palliative care and those who can provide palliative care, it becomes executively important to use the past success as the roadmap, innovate more shortcuts, and way forwards (WF) to improvise so that we have a master plan for the future. There are still hurdles to be overcome, manpower to be trained, and institutions and governing bodies to be created for effectively going ahead. With increasing awareness comes rising expectations echoing the need to raise the standard of care. What need to be achieved are consistent efforts in terms of education, training, continuing medical education, research, evidence building, formulation of guidelines, accessibility to drugs, and establishment of national as well as international bodies dedicated to the cause of palliative care. Palliative care should be regarded and provided as a 'fundamental human right' to curb the rising twister of unnecessary pain, suffering, and to ensure a 'good life and death'

for everyone. [4,5] More emphasis needs to stressed upon caregiver and bereavement support, a component of palliative care existing in definitions but missing in practicality. The purpose of this gliedoscopic article is to envision how palliative care might manifest in the future based on the journey taken till now, barriers existing, and breakthrough advances. The aim is to project what can and should be achieved, that is, 'goals for the future'.

- 'Equitable, cost-effective evidence base palliative care' to those in need irrespective of the diagnosis, prognosis, and geographical location
- Encouraging 'specialization in palliative care' as in other medical specialties
- Employing 'multidisciplinary' approach to palliative care
- Accessibility to essential drugs and
- Professional caregiver and bereavement support
- Building an environment conducive to supporting people throughout their illness spectrum
- Compassionate home and community-based palliative care supporting patient as well as carer
- Establishment of national and international governing bodies dedicated to the cause of palliative and end-of-life care (EOLC)
- Allocation and procurement of appropriate funds for resource, capacity and manpower building
- Encouraging corporate involvement; and
- Legislative stand on ethical and medico legal issues related to palliative and EOLC.

Definitions: Are they perfect?

Every scientific text usually begins with definitions, which helps in delineating what is to be dealt and avoids straying away from the core theme. Palliative care saw its first breakthrough recognition in 1986 with World Health Organization (WHO) defining and then again redefining it in 2002 as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual."[6,7] The new WHO definition unlike the older one stresses upon providing palliative care early in the course of illness and not restricting it to late stages. It has its basis upon supporting patients suffering from chronic diseases with high symptom burden and their family members. The "American Cancer Society" (ACS) and "National Cancer Institute" (NCI) definitions of palliative care also focuses upon patient and caregiver rather than the disease as its core concept. [8,9] The NCI definition extends further to incorporate symptomatic relief 'as early as possible' and to treat symptoms caused by therapeutic measures as well.[9] 'Palliative care' is different from 'hospice care' which is supporting patients at end of life to allow them to die in comfort and with dignity.[10] The Medicare Hospice Benefit reimburses hospice care to terminally ill patients with a prognosis of less than equal to 6 months on per diem basis. [11,12] This prognostic deadline imposes an ethical dilemma on the referring physician in accurately predicting the prognosis; hence the rising call for decoupling this referral requirement.[11,13] Unlike hospice care, there are no time restrictions in palliative care. There is a rising felt need of palliative care in diseases other than cancer both communicable and noncommunicable. [14,15] It is neither the diagnosis nor the prognosis, but the requirement that should define the need of palliative care.[16-18]

'Era of specialization' within palliative care

Progress till now has brought us from the question of 'whether palliative care is important or required?' to 'who should provide it?' and 'how to ensure an unbiased and equitable delivery?' In the existing healthcare system everyone is a specialist, with diverse specializations working together towards common goals for patients.^[19] To reflect existing practice in Europe and other developed countries, the European School of Oncology (ESO) has further modified the definition and gives two new definitions reflecting the growing specialization within the field of palliative care [Table 1].^[5,20]

The Global Atlas of Palliative Care, 2014 enumerates three levels (palliative care approach and general and specialist palliative care) at which palliative care should be delivered. The contribution from each will vary from country to country with specialist care meeting 30–45% of total need in high-income countries.

Statistics and logistics: Defining the future need

Quantifying the future need, its demographic and geographical distribution will help in defining the palliative care resources inclusive of manpower, funds, equipment, infrastructure required, and their allocation proportional to the requirement in order to ensure universal accessibility. The requirement of palliative care is steadily increasing both in developed as well as the underdeveloped parts of the globe and the trend is going to persist in the future due to:

 Statistics shows that there is an 'increasing incidence of cancer' and cancer-related morbidity. [15-19] The main

Table 1: Levels of palliative care and EOLC			
Level of care	Definition	What's new?	
Palliative care	A person-centered attention to physical symptoms and to psychological, social, and existential distress and cultural needs in patients with limited prognosis, in order to optimize the quality of life of patients and their families or friends	Individualizing the care according to the symptoms. Emphasis on existential distress and differing cultural needs. Patient being part of a decision-making team	
Basic palliative care	The level of palliative care which should be provided by all healthcare professionals, in primary or secondary care, within their duties to patients with life-limiting disease Basic level of care to be provided to all cancer patients with with problems that can be easily dealt		
Specialized palliative care	The standard of palliative care provided at the expert level, by a trained multi-professional team, who must continually update their skills and knowledge, in order to manage persisting and more complex problems and to provide specialized educational and practical resources to other nonspecialist members of the primary or secondary care teams		
End-of-life care (EOLC)	The specific application of palliative care interventions and services in the last hours, days, or weeks of life		
Basic EOLC	Palliative care interventions and services by all healthcare professionals in the last hours, days, or weeks of life	All healthcare professionals should have basic skill and knowledge of end-of-life issues and care	
Specialized EOLC	EOLC provided by multiprofessional palliative care team in the last hours, days, or weeks of life	Specialized care to those dying with difficult problems like 'unrelieved pain'	

EOLC: End-of-life care

reason stipulated for an increasing incidence of cancer is increasing size and elderly population. The predicted future incidence of cancer in different countries are as follows [Table 2]

- Growing proportion of older people and people living with chronic life-threatening diseases. The global population aged > 65 years is projected to increase from 550 million (2010) to 973 million (2030), [30] 6.9 to 12.0% worldwide, 15.5 to 24.3% in Europe, 14.1 to 19.9 million in UK,[31] 12.6 to 20.3% in North America, 6.0 to 12.0% in Asia, and 5.5 to 11.6% in Latin America and the Caribbean. [32] An increasing number of elderly people will potentially be associated with increased healthcare costs and requirement of personal and public resources. With increasing elderly population, the demand for institutional care at end of life is projected to increase as the proportion of elderly will outweigh that of carers. As the median age of the population is increasing, they are living more with chronic diseases. It is estimated that males and females will spend approximately 14.7 and 16.9 years, respectively in poor general health.[33] The proportion of 'very old', that is, those living more than 80 years is also projected to rise steeply in the future. Of particular concern is rising incidence of dementia as an estimate is that one in three elderly will die with
- Not only the population of people growing older, suffering from cancer and other life-threatening diseases is increasing, but simultaneously the population of the caregivers dealing with issues like economic loss, emotional turmoil, absence from work, etc., is also increasing. An ideal palliative care will not only support the patient but also these caregivers throughout the continuum of diagnosis, treatment, end of life, and

Table 2: Predicted future increase in cancer incidence in different countries

Country	Period	Predicted future increase cancer incidence	
United states	2010-2030	1.6 million (2010) to 2.3 million (2030), that is, 45% increase	
Switzerland	2005-2019	Males: 20,005 (2005 2009) to 25,910 (2015-2019), that is, 30% increase. females: 16,913-20,359 (2015-2019), that is, 20% increase	
United Kingdom	2007-2020	Males: 19%, females: 13%	
Australia	2007-2020	40% increase	
India	2010-2020	936,908 (2010) to 1,044,650 (2020)	

even bereavement. Capacity building to deal with these issues is of utmost importance

- The realm of palliative care should be expanded beyond cancer to other chronic diseases with high symptom burden. There is a rising incidence of chronic diseases due to lifestyle disorders such as obesity, diabetes mellitus, hypertension, heart diseases, stroke, etc., with people living with more than one disease all contributing to the symptom burden and requirement of palliative care. Incidence of chronic infectious diseases is also increasing. Therapeutic advancements have created a scenario wherein people are living with chronic diseases like heart failure, diabetes, etc., Palliative care issues in chronic diseases other than cancer are undecided and an unexplored area. A single approach will be inadequate necessitating development of new models of care to answer these diversities
- Scientific progress leading to innovation of more curative and life-prolonging therapies, that is, people living longer with disease and symptoms
- Increasing awareness about palliative care and concepts of autonomy.

Achievable goals for the future

Equitable evidence-based palliative care to all: An
exponentially increasing requirement of palliative care is
posing a huge challenge to currently existing resources.
Procuring manpower and capacity building [Figure 1],
especially in developing world is of utmost importance
to curb this rising deficit.

Capacity building to curb the rising deficit by:

- Preventing 'brain-drain' from developing to developed countries enabling more workforce availability where services are already deficient
- Imparting skills and knowledge to healthcare professionals from developing countries by their proficient foreign colleagues, that is, 'East meeting the West'
- WFIncorporation of palliative medicine into undergraduate curriculum and giving it a status of specialty in itself. Conjoint training initiatives such as one proposed by Seely et al., by diverse specialties may help in curbing the rising palliative care deficit^[35]
- WFIntegration of palliative care into the structure and financing of nation's healthcare systems as advised by WHO [Figure 2].^[36] Palliative care has been regarded to be a part of all national health programs aimed at reducing the overall burden of cancer and acquired immunodeficiency syndrome (AIDS).^[37] The palliative care resolution of the WHO executive board "Strengthening of palliative care as a component of integrated treatment within the continuum of care" stresses upon the importance of integration of palliative

- care into country's healthcare system, training manpower, ensuring availability of opioids and other drugs, and formulation of policies. What is required and to be seen is to what extent this can be employed in different countries with different socioeconomic background
- WFFormation of state, national, and international
 palliative care societies with necessary registration of
 palliative care physicians both general and specialist.
 Provision of temporary deputation with pay protection
 of palliative care physicians to the areas of need.
 However, such a provision should be made optional
 and not enforced to ensure continued interest of
 physician in palliative care
- Formation of organizations such as 'National Council for Palliative Care' dedicated to improvisation of palliative care at national as well as international levels
- With increasing population of older and ill people, capacity building within families, communities, and societies will be of utmost importance to ease the burden. Rising life expectancy, lowering birth rates, and societal changes will mean more and more people living alone and requiring support of relatives, friends, and neighbors in times of ill-health. There is no other healthcare sector where the role of voluntary participation is as important as in palliative care.

 WFRegular training of social workers and allied health professionals to provide doorstep palliative care will take a center stage in the future. WFAiming for university students, medical and nursing students, school teachers, armed forces, insurance agents, and public health

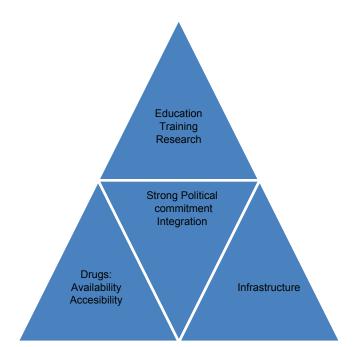


Figure 1: Essential components of capacity building

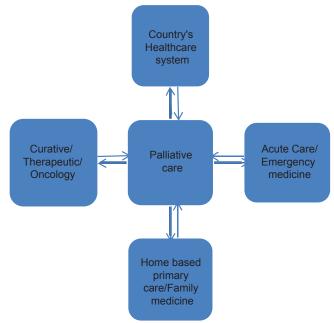


Figure 2: Integration and coordination required for universal availability

department employees as part-time palliative workers will ensure multipronged advantages as:

- Easy access to more manpower under one roof
- Reaching the population already primed to society-related causes and wanting to make their contribution
- More and more people taking up the cause owing to 'peer pressure'
- Mobile population and within easy reach to the community
- They are usually considered as respected and trustworthy members of the community; therefore little effort required for establishing 'provider-patient trust'
- Since they are part of the targeted community, they are more cognizant of the needs, cultural, economic, social, and religious values of the people.

WF Palliative care teams' comprising of a physician and nursesshould be allocated to a geographical territory to coordinate with all such workers working in their territory, provide solutions, and deal with complexities.

- Building a congenial environment in which families, communities, districts, and states mutually support each other sharing manpower and resources
- WFProvision of 24/7 pain and palliative care services within easy reach to whomsoever in need of them
- WFUtilization of technology and media for propagating the cause of palliative care. Provision of toll free numbers and speed dials to community workers, nurses, and physicians will ensure hassle-free inter- and patient-provider communication. Easy access of internet to all in the near future would mean another effective, easy, and rapid means of communication between the patient and the provider. All these will require a strong political commitment, healthcare professional's dedication, and 'public-private partnerships'.
- Corporate model of palliative care: Private and corporate hospitals delivers healthcare services to majority of population in India. It is this healthcare sector which is most reluctant in including palliative care in its services spectrum. WFIn order to ensure an equitable availability, it is of vital importance to prime this money-centered health system regarding the benefits of palliative care by [Figure 3]
- Ensuring availability of essential drugs to those in needs: Right to essential medicines including opioids has been advocated as human right. [39-41] However, the

concept of implementation of essential medicines is flexible and individual nation should take into account the needs and resources available while formulating one for themselves. International Association for Hospice and Palliative Care (IAHPC) has formulated a model list of 33 drugs for symptomatic relief of pain, constipation, nausea, vomiting, anxiety, depression, diarrhea, delirium, etc., so common in cancer and other chronic diseases. [42-44] There is still an adequate access to opioids in some especially undeveloped parts of the world.[45] According to Seya et al., 87% of countries have inadequate access to opioids.^[46] Weak national drug control policies, regulatory restrictions, fear of addiction, diversion, legal implications, and inadequate knowledge have been stipulated as the most common reasons for the above. Despite its growing recognition, neuropathic cancer pain is still underrecognized and inadequately treated.[47] Lack of knowledge regarding its existence, screening tools, and high costs of antineuropathic drugs are some of the causes to be accounted for. WFIt is of utmost importance to ensure availability and easy access to these essential drugs at an affordable price to reduce the symptomatic and public health burden of diseases.

Recent Developments-Narcotic and Psychotropic substance (NDPS) Act, 2014

The historic amendment of NDPS Act of India was done in 2014 with the aim of ensuring easy and uniform availability of opioids for medicinal purposes to those in need by:

- The amendment of rules power will be vested with the central government; ensuring uniformity for all states and union territories
- A single order instead of the existing practice of four to five licenses would enable them as recognized medical institution to procure and dispense essential opioids like morphine
- Licensing will be required only from drug controller of the state rather than the current practice of multiple agencies; thereby, simplifying and encouraging more and more institutions to dispense morphine to patients in severe pain.

WPThe need of the hour is to formulation, amendment, and most importantly enactment of such acts with modifications pertaining to sociocultural and legal differences in individual countries to ensure global uniformity and availability of morphine and other essential opioids to the needful.

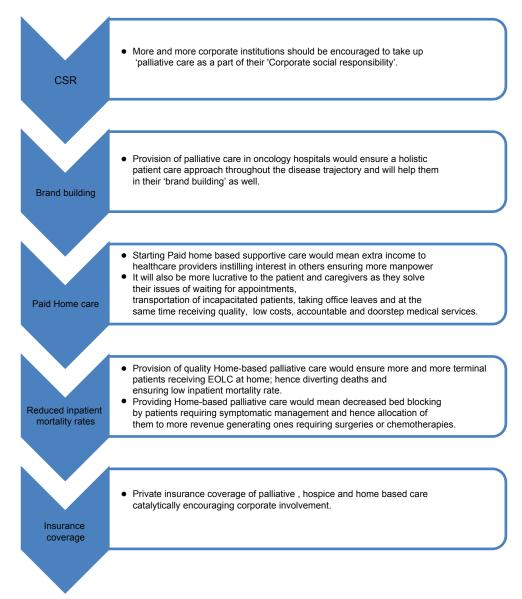


Figure 3: Encouraging corporate involvement

Drifting from unidisciplinary to a multidisciplinary level of care: Contemporary palliative care definitions from various organizations stresses upon multidimensional suffering and their improvement as its goal throughout the illness trajectory.[11] People are also getting more cognizant of the healthcare services provided to them, choices available, and want to be increasingly involved in decision making; necessitating a more 'personalized care approach'. In a world of increasing consumerism it becomes of vital importance to provide specialized and multidisciplinary services to meticulously meet the varying needs. WPTherefore, coming future is going to witness a multidisciplinary team approach to palliative care comprising of palliative care physicians, pain specialists, occupational therapist, physiotherapists, palliative care nurses, psychiatrists, and psychologists among others. A team approach allows a patient to be approached from different angles, thereby enabling a 360° of care (total care) and quality services. WPThere is a pertinent felt need for simultaneous provision of curative therapies and palliative care, that is, an 'Integrated Curo-Palliative' instead of 'Curative vs Palliative' approach to patient care [Figure 2]. An integrated approach will ensure that none of them is left behind, improves patient satisfaction, and maintain the balance towards a holistic patient care. The focus of care will depend upon the stage, prognosis, and response to therapeutic modalities with more emphasis on palliative care needs as the disease progresses. [6] Coleman et al., have developed and validated a care transition measure to characterize the transition success between different care settings.^[48] A conjoint 'curo-palliative' model will allow pooling, and hence, capacity building of healthcare professionals, funds, and other resources under one roof. Hauser et al., have stressed the importance of integration of palliative and cancer care and navigation with a navigator guiding a patient from access to diagnosis to hospice care in improving patient's outcome. [11] The philosophical and clinical differences perceived between oncology and palliative care are only superfluous. The core concepts of palliative care, that is, mitigating suffering and managing symptoms forms a major component of oncology practice as well. [49] At present, significant barriers exists hindering timely referral to palliative care which needs to be overcome to ensure care and quality at end of life.[50] WPTo achieve these, streamlined practices needs to be formulated taking physical, psychosocial factors, and patient/caregiver desires into consideration^[51]

Strengthening of community and home-based palliative care: It has been estimated that approximately 90% of people require terminal medical care near death. [52] There is clearly a mismatch between patient's preferred and actual place of death.^[53] Hospital-based care is costly, opposite of what the patient wants. WFIt is important to provide provision of choice of places where depending upon the circumstances care can take place like home, hospitals, day care, extended care centers, and palliative care units.^[54] This would ease the economic burden on patients by reducing acute hospital admissions. WFEstablishment and validation of criteria for admission into palliative care units, specialized care, and intensive care units (ICUs) will help in streamlining, avoiding unnecessary admissions and financial expenditures. WFAlso of equal importance

- is to provide a 'continuum of care' [Figure 4], 'planned discharges', and effective communication between healthcare professionals when patients are transferred from one to another level for example from intensive care unit to ward to home to ensure seamless transition of care, avoidance of therapeutic breaks, and unnecessary readmissions. [55] This continuum of care will reinforce the healthcare system gesture of "I am there for you", provide emotional support, and instill confidence in caregivers while discharging and providing homecare. National Institute for Clinical Excellence (NICE) guidance on palliative and supportive care also stresses upon repeated assessment and discussion of patient's needs throughout illness trajectory from diagnosis till near death; the global implementation of which is still pending. [56] WFThe guidance recommends that teams should promote continuity for patients and nomination of a co-coordinating 'key worker' (referred to as 'Navigator' by some).[11,56] Even specialist palliative team care integrated into primary care provided by family doctor with close coordination between the two can be provided at home [Figure 2].^[57] Such an approach can provide specialist medical interventions, equipment, and technical support at patient doorstep^[58]
- Caregiver and bereavement support: It has been estimated that in Canada wellbeing five people is affected by each death. With a growing rate of death the caregiver population is projected to increase in the future. We lack both in terms of capacity and expertise for acknowledging complex issues faced

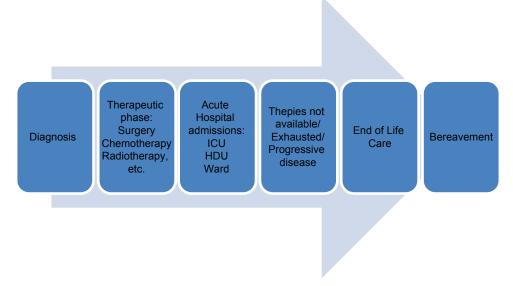


Figure 4: Continuum of palliative care throughout illness trajectory and beyond. ICU = Intensive care unit, HDU = high dependency unit

by this segment of the population. WF Caregiver Support'should include but not restricted to:

- Imparting education and training to provide cost-effective care at home
- Counseling to manage and counteract stress
- Emotional
- Occupational, and
- Bereavement support and counseling
- Financial assistance
- Sensitizing them to shift from passive to active mode by diverting them with compassion from grief and bereavement (passive mode) to active community palliative care workers (active mode).

Bereavement support should be provided to all bereaved families with special emphasis on those at high risk.^[59] Simple interventions, family meetings, and brochures concerning grief for families have been found to improve bereavement outcomes and reduce posttraumatic stress disorder.^[60] WFAII medical professionals and community workers involved with EOLC should be well-accustomed with the identification of bereavement symptomatology (emotional distress and somatic manifestations), effective counseling, psychotherapy, and criteria for referral to psychiatrist for intractable and complex cases. Medicare regulation requires hospices to provide bereavement services for 1 year post death.^[11]

Ethico-legalissues related to palliative care and EOLC: Debate regarding 'good palliative care' versus 'euthanasia' with both considered antithesis to one another is a never lasting one and is going to catch further momentum in the coming future. With increasing recognition of patient's autonomy a firm legislative stand on issues like living will, advanced care directives, healthcare proxy, and double effect will be required. These advance directives have been found to make difference for patients afflicted with serious illness and are monitored as a quality measures by some. [11,61] The Mental Capacity Act enables cognitively sound people to make advanced decisions to refuse treatment prior to loosing capacity to do so. [62] Distinction with unambiguous definitions will have to be made between 'active euthanasia', 'passive euthanasia', and 'do not resuscitate (DNR)'. Efforts to educate the public regarding such issues have been undertaken by some institutions. [63,64] WF Nationwide surveys and discussions among laymen, lawyers, bureaucrats, and physicians so that everyone's perspectives are taken into account will be required to formulate a legal framework for such politically sensitive issues. Artificial feeding, terminal hydration, parenteral nutrition, and administration of

antibiotics in prognostically poor at end of life have been found to be futile by some but they still prevail in majority of clinical practice. [54] WFConcentrated researches pertaining to these, their counterproductive effects, formulation and global enactment of evidence, and guidelines based on such research outcomes will be necessary to reduce unnecessary suffering, avoiding life prolonging measures, and at the same time discouraging hastening of death, that is, the main theme of palliative care. [7] Also there is increasing felt need to identify criteria as well as their legal implications of orders like 'DNR'. Volicer and Hurley in a special dementia unit have devised a unique supportive care approach consisting of five levels of approach: (a) Full support, (b) DNR, (c) DNR plus 'do not transfer (DNT)', (d) DNR plus DNT plus 'do not work up fevers', and (e) all of the above plus 'do not tube feed'. Comparison revealed that only 2% of patients versus a third in a regular dementia care unit died receiving full care. [65] Medical curriculums and training programs and textbooks are shown to be deficient in end-of-life issues.^[66,67] Communication and psychosocial skills to those caring for terminally-ill patients should be included in the curricula as they have been found to be easily taught. [68] WF Palliative and EOLC should receive more governmental attention with parliamental sessions dedicated to above and pertinent issues relating to them.

DISCUSSION

'Palliative care movement' is gaining momentum with increasing allocation of funds by some governments and a number of private institutions, particularly those dedicated to oncology, getting a feel that they might lag behind if palliative care remains to be eluded from their healthcare services spectrum. [69,70] A number of political acts are being proposed and implemented around the globe giving people choice and power to choose care for them. Since the new millennium; numerous certification programs, textbooks, and journals dedicated to palliative care have come up.[11] However, all these are still in their incipient stages with most of the palliative care reforms happening in developed countries like United Kingdom (UK). Its blueprints with modifications to suit the differing needs and demographics and sociocultural conditions may act as a doorstep to success of palliative care in other countries as well.

CONCLUSION

Palliative care is both an art and science of care. The future is going to witness a 'palliative care explosion' as far as

its requirement is concerned. An increasing proportion of older people, people living with comorbidities in combination and with varying severities, rising incidence of cancer as well as cancer afflicted living longer, and above all recognition of supportive and symptomatic care requirement in diversified pathophysiologal diseases explains this explosion of need. We are already facing barriers of need-supply deficit and unequal distribution; and therefore it is of vital necessity to build resources and train manpower to overcome these existing hurdles and enter a 'palliative care era'. For effectively going ahead it is of utmost importance to integrate palliative care into medical education, healthcare system, and societal framework. It should be considered as an adjunct not an alternative and complementary but not secondary to acute curative model of medicine. What is required to upheaval and revolutionize palliative care is a 'Think personal, Act global' thinking, that is, policy makers, stake holders, and health professionals realization that what care or services they would like to receive for themselves and their relatives in ill-health, take them as a standard of care, and pledge to provide the same to everyone globally. Inclusion of palliative care and EOLC is a mandatory component of physician and nurse's core curriculum worldwide; with continuing palliative care education lifelong will bridge the existing knowledge gap and manpower deficit. Political commitment, exclusive parliament sessions dedicated to palliative care, reformation of opioid policies along with nationwide discussions among lawyers, laymen, and physicians will ensure that palliative care reaches the benchmark set by the future needs. Palliative care in its broad term refers to 'care of others' is integral to human's nature. The industrialization may have led us to lose touch with that innateness, but it surely has given tools to improve our efficiency as well. It is important to embrace what it has given us, recultivate what has been eroded, and remain true to our human nature. When stalwarts such as Dame Cicely Saunders were not reluctant to take a new path so why are we hesitant to follow an already laid one?

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